NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM
FEDERAL & STATE MINIMUM STAFFING REQUIREMENTS
October 1999 Draft

Adequate numbers of well-trained, well-supervised staff are critical to quality in long term care. The Nursing Home Reform Act of 1987 (Public Law 100-203) promised each nursing home resident that s/he had the right to expect care and services from the nursing home which would allow him/her to "attain or maintain his/her highest practicable level of physical, mental, and psychosocial functioning." Unfortunately, however, Congress did not go that extra step and require a specific minimum caregiver/resident ratio or a minimum standard setting out the number of hours per patient day that a resident should be receiving care.

In 1990, Congress did require the Department of Health and Human Services to conduct a study and report to Congress by January 1, 1992 on the appropriateness of establishing minimum supervisor to caregiver to resident ratios and provide recommendations on such ratios. Only now, in 1999, is that report being completed. The Department of Health and Human Services expects such a report and recommendation to be submitted to Congress in 2000.

Until the federal report was completed, the role of setting specific standards was left to the States to develop and implement. Most states have a specific minimum standard in state law, regulation, or policy. None of those state standards, however, meet the Consumer Minimum Staffing Standard – a standard developed by nursing professionals with long term care expertise and adopted by the membership of the National Citizens' Coalition for Nursing Home Reform (in 1995 and an updated version in 1998). The Consumer Minimum Staffing Standard requires, at the very least:

FOR EVERY NURSING FACILITY:

A full-time RN Director of Nursing
A full-time RN Assistant Director of Nursing (in facilities of 100 beds or more)
A full-time RN Director of In-service Education
An RN nursing supervisor on duty at all times (24 hours, 7 days per week)

Direct caregivers (RN, LPN, LVN, or CAN)

Day	1:5 residents
Evening	1:10 residents
Night	1:15 residents

PLUS

Licensed nurses (RN, LPN, or LVN)

Day	1:15 residents
Evening	1:25 residents
Night	1:35 residents

[See attached for a complete copy of the Consumer Minimum Staffing Standard]

In addition to NCCNHR, the Consumer Minimum Staffing Standard was endorsed by the prestigious John A. Hartford foundation.

The issue of adequate staffing is becoming of greater interest to legislatures around the country. In the last year or two, approximately 2/3 of states have either promulgated a new law or regulation or ordered a committee to evaluate the information necessary to decide whether to set another (more appropriate) standard.

The attached information reviews each state’s minimum staffing standard.

FEDERAL STANDARD
As contained in the Nursing Home Reform Act of 1987

Each nursing home must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents.

Each nursing home must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.

Waivers of these standards are allowed as indicated below. If a waiver is granted, the State (under Medicaid) or the Secretary (under Medicare) must notify the long term care ombudsman and the facility must notify its residents and their immediate families.

Medicaid Facilities: States may, on an annual basis, waive the nursing requirements to the extent a home cannot meet them if:

- A facility demonstrates to the satisfaction of the state that it has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities) to recruit appropriate personnel;
- The state determines that a waive will not endanger the health or safety of residents;
- The state finds that, for any periods in which licensed nursing services are not available, an R.N. or a physician is obligated to respond immediately to telephone calls from the facility;
- If the Secretary determines that a state shows a pattern and practice of allowing waivers in the absence of diligent efforts by facilities to meet staffing patterns, the Secretary must assume the state's authority to grant waivers. A facility's reimbursement must be reduced to take into account the waivered facility's lowered costs.

Medicare facilities: The Secretary may, on an annual basis, waive the requirement for a registered professional nurse for more than 40 hours per week if the Secretary finds that:

- The facility is located in a rural area and the supply of skilled nursing facility services in the area that is not sufficient to meet the demand for such services';
- The facility has a full-time registered nurse regularly on duty 40 hours per week;
- The facility either: has only patients who do not require the services of a registered nurse or physician for a 48-hour period, as documented by the physician, or has arranged for a registered or physician to spend time in the facility as necessary to provide needed services when the regular full-time registered nurse is not on duty.

ALABAMA

No additional state minimum staffing requirement. Follows federal rule.

ALASKA

Standard
Regulation [07 AAC 012.275]

Professional Nurse Coverage
A nursing facility must have an RN on duty 7 days/week day shift, 5 days/week evening shift. An LPN must be on duty during all shifts when an RN is not present.

Facility w/ <60 occupied beds must have 2 RNs during day shift, 1 RN other shifts.

Nursing Waivers
No

ARIZONA

No additional state minimum staffing requirement. Follows federal rule.

ARKANSAS

Standard
Staffing legislation passed in 1998 – Act 1529.

By June 30, 2000 nursing homes are required to maintain the following ratios:

CNAs: 1:8 Day Shift
Licensed Personnel (RN, LPN, LVN): 1:30 Day Shift
1:12 Evening Shift
1:30 Evening Shift
1:18 Night Shift
1:50 Night Shift

By September 30, 2000, nursing homes are required to maintain the following ratios:

CNAs: 1:7 Day Shift
Licensed Professionals (RN, LPN, LVN): 1:15 Day Shift
1:12 Evening Shift
1:15 Evening Shift
1:18 Night Shift
1:35 Night Shift

Professional Nurse Coverage
Facilities containing 70 or more beds must employ an RN supervisor during the day and evening shifts in addition to the above requirements.

Facilities containing 100 or more beds must, in addition to the above requirements, employ an RN supervisor during the night shift; employ a full-time assistant director of nursing; and employ a full-time RN director of in-service education.

Staff Counted in Standard
Individuals employed to provide services such as food preparation, housekeeping, laundry or maintenance services shall not be counted in determining the above staffing ratios.

Staffing Disclosure
Nursing homes must post on each hall, wing, or corridor the number of licensed and unlicensed personnel on duty at each shift. The posting will consist of a sign-in sheet where the staff member must sign in upon arrival and again upon departure. The current number of residents on that unit shall also be posted at the same place as the staffing report. This information must be posted in a conspicuous place and in a manner which is visible and accessible to all residents, families, and visitors.

Nursing Waivers
No

CALIFORNIA

Standard
Welfare & Institutions Code 14110.7 (California regulation) requires the minimum nursing hours to be:

SNF = 3.0 hours/patient day
SNF w/ special treatment program = 2.3 hours/patient day
NF = 1.1 hour/patient day
NF/Developmentally Disabled = 2.7 hours/patient day

Professional Nurse Coverage
22 CCR 72329 Nursing Service – Staff
-- Facilities licensed for 59 or fewer beds must have at least one RN or LVN awake and on duty, in the facility at all times, day and night
-- Facilities licensed for 60 – 99 beds must have at least one RN or LVN awake and on duty, in the facility at all times, day and night, in addition to the director of nursing services. The DoN shall not have charge nurse responsibilities.
-- Facilities licensed for 100 or more beds must have at least one RN awake and on duty, in the facility at all times, day and night, in addition to the director of nursing services. The DoN shall not have charge nurse responsibilities.

22 CCR 73319 – Nursing Service Staff
-- Facilities must employ an RN or LVN 8 hours per day on the day shift, 7 days/week.
-- Facilities with 100 or more beds shall employ an RN 8 hours per day on the day shift, 7 days/week. Additionally, an RN or LVN must be employed 4 hours per day, 7 days per week, during the day for each 50 beds or portion thereof in excess of 100.

Staff Counted in Standard
"Nursing hours" means the number of hours of work performed per patient day by aides, nursing assistants, or orderlies, plus 2 times the number of hours worked per patient day by registered nurses and licensed vocational nurses, and in distinct part of facilities and freestanding facilities providing care.

Nursing Waivers
1276.2 of the Health & Safety Code includes a prohibition on the requirement of the use of registered nurses in SNFs for which vocational nurses are qualified, when the facility is unable to obtain a registered nurse.

COLORADO

Standard
Code of Colorado Regulations 1011, Chapter 5, Part 7
Nursing care facility must provide nurse staffing sufficient in number to provide at least 2.0 hours of nursing time per resident per day.

Professional Nurse Coverage
Nursing care facility: at least one RN must be on duty (and on the premises) at all times [except as provided under section 7.6].

Each resident care unit must be staffed with at least a licensed nurse.

Intermediate care facility: at least one RN or LPN must be on duty (and on the premises) on the day shift 7 days/week. Facility may use LPN as DoN.

Nursing facility required to employ a full-time Director of Nursing who is an RN and qualified by education and experience to direct facility nursing care.

Staff Counted in Standard
If 60+ residents, the time of the DoN, Staff development Coordinator, and other supervisory personnel who are not providing direct resident care may not be used in computing this ratio.

Nursing Waivers
Waivers of the RN requirement may be granted if:
- facility is located in a rural area;
- the facility has at least one FT RN who is regularly on duty;
- facility has only residents whose attending physicians have indicated that each resident does not require the services of an RN for a 48-hour period or the facility has made arrangements for a professional nurse or physician to be on-site as necessary to provide needed services when the regular FT RN is not on duty; and
- facility has made a good faith effort to comply with the RN requirement but RNs are unavailable in the area.

CONNECTICUT

Standard
Connecticut Public Health Code Sec. 19-13-D8t

Minimum staffing for chronic and convalescent nursing home:
Licensed nursing personnel
7 am - 9 pm = .47 hours/patient
9 pm - 7 am = .17 hours/patient
Total nursing & nurses' aide personnel
7 am - 9 pm = 1.40 hours/patient
9 pm - 7 am = .50 hours/patient

Minimum staffing for a rest home with nursing supervision staff:
Licensed nursing personnel
7 am - 9 pm = .23 hours/patient
9 pm - 7 am = .08 hours/patient
Total nursing & nurse?s aide personnel
7 am - 9 pm = .70 hours/patient
9 pm - 7 am = .17 hours/patient

Professional Nurse Coverage
There shall be at least one RN on duty 24 hours per day, 7 days per week

In a chronic and convalescent nursing home, there must be at least one licensed nurse on duty on each patient occupied floor at all times.

In a rest home with nursing supervision, there must be at least one nurse's aide on duty on each patient occupied floor at all times and intercom communication with a licensed nurse.

Staff Counted in Standard
In facilities of 61+ beds, the DoN shall not be included in the above requirements.

In facilities of 121+ beds, the AdoN shall not be included in the above requirements.

Nursing Waivers
No

DELAWARE

Information unreported as of 10/99

DISTRICT OF COLUMBIA

No additional state minimum staffing requirement. Follows federal rule.

FLORIDA

Standard
Title 59A-4 Florida Administrative Code
- At a minimum, the facility will staff an average of 1.7 hours of certified nursing assistant and 0.6 hours of licensed nursing staff time for each resident during a 24 hour period.
- The DoN shall designate one licensed nurse on each shift to be responsible for the delivery of nursing services during that shift.
- In a multi-story, multi-wing, or multi-station facility, there shall be a minimum of one nursing services staff person who is capable of providing direct care on duty at all times on each floor, wing, or station.

Note: In 1999, the Florida legislature passed legislation giving nursing homes $40 million to increase staffing and CNA wages, but it did not legislatively require specific staffing ratios.

Professional Nurse Coverage
When a DoN is delegated institutional responsibilities, a full-time qualified RN must be designated to serve as Assistant DoN.

Facilities with a census of 121 or more residents must designate an RN as an Assistant DoN.

Nursing Waivers
No

GEORGIA

Standard
Georgia DHR Rules, chapter 290-5-8-.04
- A minimum of 2.0 hours of direct nursing care per patient in a 24 hour period.

- For every 7 total nursing personnel required, there shall not be less than one registered nurse or licensed practical nurse.
- Nursing staff shall be employed for nursing duties only.

Medicaid policy
- Level I and Level II nursing facilities are required to provide a minimum of 2.5 nursing hours per patient day.

Professional Nurse Coverage
There must be at least one nurse, registered, licensed undergraduate, or licensed practical on duty and in charge of all nursing activities during each 8-hour shift.

An RN shall be employed full-time as DoN. She may not also be the administrator.

Nursing Waiver
No

HAWII

Standard
Department of Health Regulations, 11-94-23

Professional Nurse Coverage
Skilled Nursing Facility -- at least one RN, full-time, 24 hours per day, 7 days per week

Intermediate Care Facility -- at least one RN, full-time, on day shift and at least one licensed nurse whenever medications are administered.

IDAHO

Standard
IDAPA 16.03.02200,02

Skilled Nursing Facilities
59 or less residents -- 2.4 hours/resident/day. Hours shall not include DoN but may include the supervising nurse on each shift.
60+ residents -- 2.4 hours/resident/day. Hours shall not include the DoN or supervising nurse.

Nursing Facilities
1.8 hours/resident/day. Hours may include the DoN, supervising nurse and charge nurses.

SNFs & NFs shall be considered in compliance w/the minimum staffing ratios if, on Monday of each week, the total hours worked by nursing personnel for the previous 7 days equal or exceed the minimum, staffing ratio for the same period when averaged on a daily basis and the facility has received prior approval from the Licensing Agency to calculate nursing hours in this manner.

Professional Nurse Coverage
In facilities with 60+ residents, the DoN shall have strictly nursing administrative duties
In facilities with 59 or less residents the DoN may, in addition to administrative responsibilities, serve as the supervising nurse.

SNFs with 60+ residents
- an RN shall be on duty 8 hours each day and no less than an LPN shall be on duty for each of the other 2 shifts.

SNFs with 60 - 89 residents

- an RN shall be on duty during the day shift and the evening shift and no less than an LPN shall be on duty during the night shift

SNFs with 90+ residents

- an RN must be on duty at all times.

ICFs

- an RN or LPN must be on duty at all times as charge nurse
- if an LPN is charge nurse, the facility must make documented arrangements for an RN to be on call for these shifts to provide professional nursing support

Nursing Waiver

Regulation permits waiver of RN as Superivisng or Charge Nurse if a facility is unable to hire an RN to meet the requirements so long as: the facility continues to seek an RN at a compensation level at least equal to prevailing community rates; documented record of efforts to secure RN personnel is maintained in the facility; and the facility maintains at least 40 hours/week RN coverage.

ILLINOIS

Standard

77 Illinois Administrative Code Chapter I, sec. 300.1230

Skilled Nursing Care = at least 2.5 hours of nursing care each day, of which at least 20% must be licensed nurse time.

Intermediate Care = at least 1.7 hours of nursing care each day, of which at least 20% must be licensed nurse time.

Light intermediate care shall be provided with at least 1 hour of nursing care each day, of which at least 20% must be licensed nurse time.

A resident needing light intermediate care is one who needs personal care as defined in section 1-120 of the Act; is mobile; requires some nursing services; needs a program of social services and activities directed toward independence in daily living skills; and needs daily monitoring.

At least 40% of the minimum required hours shall be on the day shift; at least 25% on the evening shift; and at least 15% on the night shift.

Professional Staff Coverage

A licensed nurse must be designated as a charge nurse when neither the DoN or Assistant DoN are on duty. If both RNs and LPNs are on duty, this person shall be an RN.

SNFs = at least one RN must be on duty 8 consecutive hours, 7 days per week

There shall be at least one RN or LPN on duty at all times in an ICF or a SNF.

Staff Counted in Ratios

The DoNs time shall not be included in staffing ratios

Nursing Waivers

Yes

INDIANA

Standard
410 IAC 16.2-3.1-17

Except when waived, facility shall provide a licensed nurse hour to resident ration of 0.5 licensed nurse hour per resident day, averaged over a one week period.

Professional Staff Coverage
Facility must designate a licensed nurse to serve as charge nurse on each tour of duty.

Facility must have an RN on duty for at least 8 consecutive hours per day, 7 days a week.

DoN may serve as charge nurse only when facility daily occupancy is fewer than 60 residents. These hours may be counted toward the staffing requirement.

Nursing Waivers
Yes if:
- facility demonstrates it was unable to recruit proper personnel
- a waiver would not endanger the health or safety of the residents
- an RN or physician is on call at all times and required to respond immediately to calls
- state agency provides notice to the LTC Ombudman and the protection and advocacy system

IOWA

Standard
IAC 58.11(2)
- The minimum hours of resident care personnel required for residents needing intermediate nursing care shall be 2.0 hours per resident/day computed on a 7-day week. A minimum of 20% of this time shall be provided by qualified nurses.
- If the maximum medical assistance rate is reduced below the 74th percentile, the requirement will return to 1.7 hours per resident/day computed on a 7-day week. A minimum of 20% of this time shall be provided by qualified nurses.
- The minimum hours of professional nursing personnel for residents requiring skilled nursing care shall be 168 hours per week for facilities under 50 beds. For every additional bed over 50, 2.24 hours of additional nursing per week is required.
- Non professional nursing care staff shall be required in the ratio of 0.28 employee per bed, per week.

Professional Nurse Coverage
An ICF with 75+ beds must have a qualified nurse on duty, 24 hours a day, 7 days a week

An ICF with less than 75 beds that employs an LPN as a health service supervisor must also employ an RN for at least 4 hours each week for consultation. The RN must be on duty at the same time as the supervisor.

Facilities with 75+ beds must employ a health services supervisor who is a registered nurse.

A SNF must provide 24 hour service by licensed nurses, including at least one registered nurse on the day shift, 7 days per week.

The health service supervisor must not serve as the charge nurse in a SNF with 60 + residents.

Staff Counted in Standard

The health supervisor's hours worked per week shall be included in computing the 20% requirement.

KANSAS

Standard
Kansas Administrative Regulations, 28-39-154

Per facility, there shall be a weekly average of 2.0 hours of direct care staff time per resident and a daily average of not fewer than 1.85 hours during any 24 hour period.

The ratio of nursing personnel to residents per nursing unit shall not be fewer than one nursing staff member for each 30 residents or for each fraction of that number of residents.

A licensed nurse shall be on duty 24 hours per day, seven days per week. An RN must be on duty at least 8 consecutive hours per day, 7 days per week.

On the day shift there shall be the same number of licensed nurses on duty as there are nursing units.

Staff Counted in Standard
The DoN shall not be included in the weekly and daily average computation in facilities w/ < 60 beds.

However, the DoN may be counted to meet the licensed nurse on duty requirement.

KENTUCKY

No minimum staffing standard exists in Kentucky. The Licensing Agency provided the following clarification:

The Division of Licensing and Regulation has followed the lead of the Federal Government in that the licensing regulations reflect the certification regulations regarding minimum staffing requirements. The reasons are as follows:

- Often when minimum staff requirements are established, the minimum then becomes the maximum;
- Acuity levels of residents may change on a daily basis, and thus it would not be possible to predict what staffing ratios are necessary; and
- Minimum staff ratios would hamper our ability to utilize an outcome based survey process as well as providing a defense for nursing homes to employ anytime a deficiency is cited related to "understaffing."

LOUISIANA

Standard
Louisiana Licensure Standards, sec. 9811

As a minimum, the nursing home shall provide 1.5 hours of care per resident each day

Nursing homes participating in Medicaid shall be required to meet the following standards for payment for nursing home services in addition to the standards currently in effect:

- the ratio of nursing care hours to residents shall be 2:35 on intermediate care level residents

- the ratio of nursing care hours to residents shall be 2:60 on skilled level residents

Professional Nurse Coverage
Licensed nurse coverage must be provided 24 hours per day.

The DoN may serve as charge nurse only when 60 or fewer residents.

Nursing homes with a census of 101 + must have an assistant DoN who shall be an RN unless written waiver is received from the Department of Health.

Nursing Waiver
Waiver permitted if facility is unable to obtain 7-day RN coverage. Request for waiver must include proof that diligent efforts have been made to recruit appropriate personnel, and names and phone numbers of RNs interviewed for the job. Louisiana also follows federal waiver provisions, contained in the Nursing Home Reform Act of 1987.

MAINE

Standard
10-144 CMR 110, chapter 9

Day shift = 1:8
Evening shift = 1:12
Night shift = 1:20

Professional Staff Coverage
An RN must be on duty for at least 8 consecutive hours each day of the week.

Day Shift:
- a licensed nurse must be on duty 7 days/week
- an RN must be designated as the charge nurse -- in facilities with less than 20 beds, the DoN may also be the charge nurse
- an additional licensed nurse must be added for each 50 beds above 50.
- In facilities with 100+ beds, the additional licensed nurse must be an RN for each multiple of 100 beds

Evening Shift:
- A licensed nurse must be on duty 8 hours each evening
- An additional licensed nurse shall be added for each 70 beds
- In facilities with 100+ beds, one of the additional licensed nurses must be an RN

Night Shift
- A licensed nurse must be on duty 8 hours each evening
- An additional licensed nurse shall be added for each 100 beds
- In facilities with 100+ beds, an RN must be on duty

Staff Counted in Standard
Nurse aides in training may not be counted in the ratio

Private duty nurses shall have no effect on the nursing staff requirements.

Sharing of nursing staff is permitted between the nursing facility and other levels of assisted living on the same premises as long as there is a clear documented audit trail and the staffing in the nursing facilities remains adequate to meet the needs of residents.

MARYLAND

Standard
Code of Maryland Regulations, 10.07.02

Comprehensive care facilities shall employ supervisory personnel and a sufficient number of supportive personnel to provide a minimum of 2 hours of bedside care per licensed bed per day, 7 days per week.

Comprehensive care facilities shall provide at least the following supervisory personnel:

2-99 residents = 1 FT RN
100-199 residents = 2 FT RNs
200-299 residents = 3 FT RNs
300-399 residents = 4 FT RNs

The ratio of nursing service personnel on duty to patients may not at any time be less than 1:25 or fraction thereof.

Professional Nurse Coverage
Extended care facilities shall be staffed with an RN 24 hours a day, 7 days a week.

Nursing Waiver
Facilities with 40 or fewer beds which do not participate in a federal program may request for an exception to the above staffing pattern.

Staff Counted in Standard
Bedside hours include the care provided by RNs, LPNs, and supportive personnel, except that ward clerk's time shall be computed at 50% of the time provided on the nursing unit.

Only those hours which the director of nursing spends in bedside care may be counted in the 2 hour minimal requirement.

MASSACHUSETTS

Standard
105 CMR 150.007

Level I care shall provide, at a minimum, a total of 2.6 hours of nursing care per patient per day; at least 0.6 hours shall be provided by licensed nursing personnel and 2.0 hours by ancillary nursing personnel.

Level II care shall provide, at a minimum, a total of 2.0 hours of nursing care per patient per day; at least 0.6 hours shall be provided by licensed nursing personnel and 1.4 hours by ancillary nursing personnel.

Level III care shall provide, at a minimum, a total of 1.4 hours of nursing care per patient per day; at least 0.4 hours shall be provided by licensed nursing personnel and 1.0 hours by ancillary nursing personnel.

Level IV care shall provide:

- facilities with less than 20 beds -- at least one "responsible person" on active duty during waking hours in the ratio of one per ten residents
- facilities with more than 20 beds -- at least one "responsible person" on active duty at all times, 24 hours a day/ 7 days a week, per unit
- If none of the responsible persons on duty are licensed nurses, then the facility shall provide a licensed consultant nurse, four hours per month, per unit.

Staff Counted in Standard
The supervisor of nurses and the charge nurse, but not the DoN, may be counted in the calculation of licensed nursing personnel.

The amount of nursing care time per patient shall be exclusive of non-nursing duties.

MICHIGAN

Standard
Michigan Compiled Laws
Michigan Department of Public Health Rules sec. 333.21720a

A nursing home shall maintain staff sufficient to provide not less than 2.25 hours of nursing care per resident per day.

The ratio of residents to nursing care personnel:

- Morning shift = 1:8
- Afternoon shift = 1:12; and
- Nighttime shift = 1:15

Professional Nurse Coverage

Each nursing home must have an RN employed full-time as DoN.

There must be an RN on duty at least 8 consecutive hours per day, 7 days per week.

Each nursing home must have a licensed nurse on each shift to serve as charge nurse.

Staff Counted in Standard
In a nursing home having 30 or more beds, the director of nursing shall not be included in counting the minimum ratios of nursing personnel.

An employee designated as nursing staff shall not be engaged in providing basic services such as food preparation, housekeeping, laundry, or maintenance services

MINNESOTA

Standard
Minnesota Statutes Annotated sec. 144A.04
Minnesota Rules sec. 4658.0510

The minimum number of hours of nursing personnel to be provided in a nursing home is the greater of 2.0 hours per resident per 24 hours or 0.95 hours per standardized resident day. Regulations require that the minimum number of hours of nursing personnel to be provided is:

- 2.0 hours of nursing personnel per resident per 24 hours (for nursing homes not certified to participate in medical assistance)
- the greater of 2.0 hours per resident per 24 hours or 0.95 hours per standardized resident day (for nursing homes certified to participate in the medical assistance program.)

Professional Nurse Coverage
A nursing home must have a full time DoN who is an RN and is assigned full time to the nursing services of the facility.

A nurse must be employed so that on-site nursing coverage is provided 8 hours/day, 7 days/week.

Staff Counted in Standard
The non-productive hours of the in-service training director are not included in the above standard

In homes with more than 60 licensed beds, the hours of the DoN are excluded.

"Hours of Nursing Personnel" means the paid, on-duty, productive nursing hours of all nurses and nursing assistants, calculated on the basis of any given 24-hour period.

MISSISSIPPI

Standard
Mississippi Code Annotated, 43-11-201.1

Currently 2.33 hours per patient day. Regulation effective January 2000, requirement increased to 2.67 hppd.

Professional Nurse Coverage
RN coverage on the day shift 7 days/week.

Facilities with 180+ beds shall have an assistant DoN, who shall be an RN.

In facilities with 60 beds or less, the DoN may serve as the charge nurse. In facilities with 60+ beds, the DoN may not serve as charge nurse, nor as medication/treatment nurse.

MISSOURI

No additional state minimum staffing requirement. Follows federal rule. State standard repealed in 1998.

MONTANA

Standard
Administrative Rules of Montana 16.32.361

	In Terms of Service Furnished by Each Category of Personnel						
	Day Shift			Evening Shift			
# Licensed beds	RN Hours	LPN Hours	Aide Hours	RN Hours	LPN Hours	Aide Hours	RN Hours
4-8	8	0	0	0	8	0	0
9-15	8	0	4	0	8	0	0
16-20	8	0	8	0	8	4	0
21-25	8	0	12	0	8	8	0
26-30	8	0	16	0	8	8	0
31-35	8	0	20	0	8	12	0
36-40	8	0	24	0	8	16	0
41-45	8	8	28	0	8	16	0
46-50	8	8	32	0	8	20	0
51-55	8	8	36	8	0	24	0
56-60	8	8	40	8	0	24	0

61-65	8	8	44	8	0	28	0
66-70	8	8	48	8	0	32	0
71-75	8	8	52	8	0	32	8
76-80	8	16	48	8	8	32	8
81-85	8	16	52	8	8	32	8
86-90	8	16	56	8	8	32	8
91-95	16	16	52	8	8	36	8
96-100	16	16	56	8	8	40	8

Staffing of homes with more than 100 beds will be given individual consideration.

NEBRASKA

No additional state minimum staffing requirement. Follows federal rule.

NEVADA

Standard
Nevada Medicaid Services Manual, sec. 502.3

	Minimum Hrs ppd	Maximum Hrs ppd
Skilled Nursing Level 3	10.75	6.00
Skilled Nursing Level 2		4.00
Skilled Nursing Level 1		5.75 3.00
Intermediate Care Level 3		3.75 2.50
Intermediate Care Level 2		2.75 1.50
Intermediate Care Level 1		1.75 0.75
		1.00

Staff Counted in Standard
Direct care does not include: DoN; Assistant DoN; Inservice Coordinator; Patient Care Coordinator; Staff Development Coordinator; Ward Clerk; Medical Records Coordinator; Administrative Aide in-training; Orientees; Restorative Aides employed by Therapist; Volunteers; any RNs, LPNs or charge nurses classified as any of the above.

NEW HAMPSHIRE

Information unreported as of 10/99

NEW JERSEY

Standard
NJAC 8:39-25.1 through 25.4

RNs, LPNs, and NAs shall spend the following amounts of time on professional duties:

- Total number of residents multiplied by 2.5 hours/day; plus
- Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day:

Tracheostomy
1.25 hours/day
Use of respirator
1.25 hours/day
Head trauma stimulation/Advanced neuromuscular/Orthopedic care
1.50 hours/day
Intravenous therapy
1.50 hours/day
Wound care
0.75 hours/day
Oxygen therapy
0.75 hours/day
Nasogastric tube feedings and/or gastrostomy
1.00 hours/day

There shall be a visual observation by a member of the resident care staff of each resident at least once per hour. These observations need not be documented.

Professional Nurse Coverage
At least 20% of the hours of care required shall be provided by RNs or LPNs

An RN shall be on duty at all times in facilities with 150+ beds.

Facilities with 150+ beds shall have an assistant DoN who is an RN

There shall be at least one RN on duty in the facility during the day shift.

NEW MEXICO

No additional state minimum staffing requirement. Follows federal rule.

NEW YORK

No additional state minimum staffing requirement. Follows federal rule.

NORTH CAROLINA

Standard
North Carolina Administrative Code, Title 10, 03H.2303

Except for designated units with higher staffing requirements noted elsewhere in the subchapter, daily direct patient care nursing staff, licensed and unlicensed, shall equal or exceed 2.1 nursing hours per patient day. Inclusive in these nursing hours is the requirement that at least one licensed nurse is on duty for direct patient care at all times.

Note: North Carolina regulations also contain staffing standards for adult care homes. And, legislation to improve staffing ratios for adult care homes was introduced in 1997 in the General Assembly.

Professional Nurse Coverage
An RN shall be designated to serve as the DoN on a full time basis.

The DoN shall serve as the charge nurse only if occupancy is less than 60.

Nurse Waivers
Staffing waivers granted by the federal government for Medicare and Medicaid certified beds shall be accepted for licensure purposes.

NORTH DAKOTA

No additional state minimum staffing requirement. Follows federal rule.

OHIO

Standard
ORC 3701-17-08

- Each nursing home shall have at least one attendant on duty at all times for each 15 residents and one other person on duty at all times;
- at least one person working 40 hours per week for each 4 residents;
- and the following minimum nurse staffing which may be counted in determining the foregoing personnel requirements:

    - 10 or fewer residents = 1 nurse on duty at least 8 hours per day between 6 am and 5 pm and a nurse on call at all other times.
    - 11- 25 residents = 1 nurse on duty at least 16 hours per day between 6 am and 12 midnight and a nurse on call at all other times.
    - 26 - 50 residents = 1 nurse on duty at all times.
    - 51 - 75 residents = 2 nurses on duty at all times; provided, at least one nurse shall be an RN on duty not less than 8 hours between 6 am and 5 pm.
    - 76 - 100 residents = at least 2 nurses; an RN shall be on duty not less than 8 hours each day between 6 am and 5 pm.
    - 100+ residents = an RN on duty at all times and an additional nurse on duty at all times for every 50 residents

Nursing Waiver

Yes if:
- facility has made diligent efforts to recruit the required personnel
- facility is offering the prevailing wage for RNs and LPNs
- facility and personnel policies are such as to offer satisfactory working conditions to prospective employees

OKLAHOMA

Standard
Oklahoma Regulations 310:675-13-12

Day Shift – 1:10
Evening Shift = 1:15
Night Shift = 1:20

Professional Nurse Coverage
A licensed nurse shall be on duty 8 hours a day, 7 days a week on the day shift.

If the DoN is an LPN, an RN shall be employed for at least 8 hours per week as a consultant.

Nursing Waiver
Yes

OREGON

Standard
Oregon Administrative Rules 411-86-100

Day Shift = 1:10
Evening Shift = 1:15
Night Shift = 1:25

Professional Nurse Coverage
Licensed nurse hours shall include no less than 1 RN per resident per week.

The facility shall have a licensed charge nurse on each shift, 24 hours per day. The charge nurse must be an RN for no less than 8 consecutive hours between 7 am and 11 pm, 7 days per week.

The DoN may serve as charge nurse only when the facility has 60 or fewer residents.

Staff Counted in Standard
No more than 25% of the nursing assistants assigned to residents pursuant to the above ratio may be nursing assistants who are not yet certified.

When an RN serves in the temporary absence of the administrator, his/her hours shall not be used to meet minimum nursing hours.

In facilities with 41+ beds, the hours of a licensed nurse who serves as facility administrator shall not be included in any licensed nurse coverage.

Nursing Waivers
Yes

PENNSYLVANIA

Standard
Pennsylvania Administrative Code, title 28, chapter 211

Total number of hours of general nursing care in each 24 hour period shall be a minimum of 2.7 hours for each skilled patient and 2.3 hours for each intermediate care patient.

Professional Staff Coverage
The following daily professional staff shall be available:

Census	Day	Evening	Night
59 and under	1 RN	1 RN	1 RN
60/150	1 RN	1 RN	1 RN

151/250	1 RN & 1 LPN	1 RN & 1 LPN	1 RN
251/500	2 RNs	2 RNs	2 RNs
501/1000	4 RNs	3 RNs	3 RNs
1001/up	8 RNs	6 RNs	6 RNs

There shall be a full time DoN who shall be a qualified RN.

The DoN may also serve as the day professional staff nurse in a facility with an average daily census of 59 patients or less.

RHODE ISLAND

Information unreported as of 10/99

SOUTH CAROLINA

Standard
South Carolina State Law
SC Department of Health & Environmental Control Regulation 61-17

Recently passed legislation requires:

- In addition to the number of licensed nursing personnel required by regulation, a nursing home must provide at a minimum the following resident-staff ratios:

  9:1 for shift 1
  13:1 for shift 2
  22:1 for shift 3

Professional Nurse Coverage
Regulation states:

- The required minimum number of licensed nurses for any nursing station which serves at least 1 resident is one per station per shift. If a nursing station serves more than 44 residents, then that station is required to have 2 licensed nurses on all shifts.

The facility shall designate an RN as a full time DoN

SOUTH DAKOTA

No additional state minimum staffing requirement. Follows federal rule.

TENNESSEE

Standard
Tennessee Code, Chapter 1200-8-6-.04

A minimum of 2.0 hours of direct care to each resident every day, including 0.4 hours of licensed nursing personnel time.

The number of direct nursing hours required shall be calculated according to the following formula:

- # residents x # nursing hours required per resident day = total direct nursing hours required

- # residents x # licensed nursing hours required per resident day = total licensed nursing hours required
- divide the total hours required by the number of hours worked by a full-time person (usually 8)

Professional Nurse Coverage
At least 1 licensed nurse on duty at all times.

If the nursing service is under the direction of an LPN, an RN must be available on the nursing home premises to consult, review, and advise on the quality of nursing care for at least 48 weeks in each calendar year. The RN consultant must be on the premises at least 8 hours each week (12 hours/week in homes with 51+ beds).

In facilities with 50 beds or less, the DoN, in addition to nursing administrative and supervisory responsibilities, may participate in general nursing duties and patient care activities not to exceed 50% of his/her working hours.

TEXAS

Standard
Texas Administrative Code, Title 25, Part I, Chapter 145
Texas Dept of Human Services, sec. 19.1001,2

Professional Nurse Coverage
At a minimum, the facility must maintain a ratio of 1 licensed nursing staff person for each 20 residents or a minimum of 0.4 licensed-care hours per resident day.

The facility must designate an RN to serve as DoN on a full-time basis.

There must be a licensed nurse to serve as charge nurse on each tour of duty.

Facility must use the services of an RN for at least 8 consecutive hours per day, 7 days per week.

Staff Counted in Standard
Licensed nurses who may be counted include, but are not limited to, DoN, Assistant DoN, Staff Development Coordinators, Charge Nurses, and Medication/Treatment Nurses.

Staff, who also have administrative duties not related to nursing, may be counted in the standard only to the degree of hours spent in nursing related duties.

Nursing Waiver
Yes

UTAH
Information unreported as of 10/99

VERMONT

No additional state minimum staffing requirement. Follows federal rule.

VIRGINIA

No additional state minimum staffing requirement. Follows federal rule.

WASHINGTON

Standard
Washington Administrative Code Title 388-97-115

Skilled Care = 2.25 hppd
Intermediate Care = 2.00 hppd
Limited nursing care = 1.25 hppd

A minimum of 20% of the above hppd must be provided by nurses.

Professional Nurse Coverage
The nursing home shall have an RN on duty directly supervising resident care a minimum of 16 hours per day, 7 days per week.

An RN or LPN must be on duty directly supervising resident care the remaining 8 hours per day.

The nursing home shall designate an RN or LPN to serve as charge nurse and shall have a full time DoN who is an RN.

An intermediate care facility with:
- fewer than 60 residents shall have at least 1 RN or 1 LPN on duty during every daytime tour of duty. The RN may be the DoN.
- 60 or more residents shall have at least 1 RN on duty during every daytime tour of duty. The RN may be the DoN in accordance with paragraph (a).

A SNF shall have at least 1 charge nurse on duty at all times, and:
- if fewer than 60 residents -- at least 1 RN who may be the DoN on duty as charge nurse during daytime
- if 60 - 74 residents -- in addition to the DoN, at least 1 RN on duty as charge nurse during daytime
- if 75 - 99 residents -- in addition to the DoN, at least 1 RN on duty as charge nurse during daytime and at least 1 RN on duty as charge nurse on a non-daytime tour of duty
- if 100+ residents -- in addition to the DoN, at least 1 RN on duty as charge nurse at all times.

An intermediate care facility shall have a charge nurse during every daytime tour of duty, who may be the DoN.

WEST VIRGINIA

Standard
64 CSR 13

Minimum of 2 hours nursing personnel time per resident per day. Includes 0.4 hours of licensed nurse time and 1.6 hours of nurse aide time.

Minimum Ratios of Resident Care Personnel to Residents

Number of Residents	Licensed Nurses		Aides		Total Resid
	Number Per Day	Hours Per Day	Number Per Day	Hours Per Day	Number Per Day

	Licensed Nurses		Aides		Total Resid
3-10	3	24	3	24	6
11-20	3	24	4	32	7
21-30	3	24	6	48	9
31-40	3	24	8	64	11
41-50	3	24	10	80	13
51-60	3	24	12	96	15
61-70	3.5	28	14	112	17.5
71-80	4	32	16	128	20
81-90	4.5	36	18	144	22.5
91-100	5	40	20	160	25
101-110	5.5	44	22	176	27.5
111-120	6	48	24	192	30
121-130	6.5	52	26	208	32.5
131-140	7	56	28	224	35
141-150	7.5	60	30	240	37.5
151-160	8	64	32	256	40
161-170	8.5	68	34	272	42.5
171-180	9	72	36	288	45
181-190	9.5	76	38	304	47.5
191-200	10	80	40	320	50
Over 200	Shall be calculated for each facility				

Professional Nurse Coverage
A nursing home shall provide licensed nursing services coverage 24 hours a day, 7 days a week.

Staff Counted in Standard
In facilities with less than 60 beds, the DoN may be included in the staff:resident ratio calculations.

Employees, private duty nurses, volunteers or contracted nurses who are "available" or "on call" do not meet the requirements for minimum staffing.

No individual shall be counted as meeting these numerical requirements on any 2 consecutive shifts, unless the facility can demonstrate extenuating circumstances and only then as a non-routine occurrence.

WISCONSIN

Standard
Wisconsin Statutes, Chapter 50.04

Law requires that each nursing home shall provide at least the following hours of service by RNs, LPNs, or NAs:

- For each resident needing intensive SNF care - 3.25 hours per day, of which a minimum of 0.65 hours shall be provided by an RN or LPN.
- For each resident needing SNF care - 2.5 hours per day, of which a minimum of 0.5 hours shall be provided by an RN or LPN.
- For each resident needing intermediate or limited nursing care - 2.0 hours per day, of which a minimum of 0.4 hours shall be provided by an RN or LPN.

HFS 132, the Wisconsin Administrative Code, is currently under revision and will be made consistent with Chapter 50.04.

Professional Nurse Coverage

Each nursing home must have a charge nurse -- can be either an LPN under the supervision of an RN or MD, or can be an RN.

All facilities shall have at least one nursing staff person on duty at all times.

Nurse Waivers

Available, but rarely granted.

WYOMING

Standard

Wyoming Regulations

Regulations require:

- 2.25 hours for each resident classified for SNF services in each 24 hour period, 7 days/week
- 1.5 hours for each resident classified for intermediate care in each 24 hour period, 7 days/week

Professional Nurse Coverage

Each nursing station shall be staffed with an RN or LPN who is the charge nurse on the day tour, 7 days/week. All other tours of duty shall be staffed with an RN or LPN.

If an LPN is in charge, there shall be a minimum of 4 hours consultation given to the facility per week by an RN when the LPN is on duty.

There shall be 24 hour nursing service with a sufficient number of qualified supervisory and supportive personnel on duty at all times to meet the total needs of patients.

STATE ACTIVITIES IN 1999 RELATED TO STAFFING
WORKING UPDATE
NOVEMBER 1999

Prepared by the Paraprofessional Healthcare Institute

This "working update" reports on state activities related to staffing. It is based on information from the NCCNHR advocacy network, including State LTC Ombudsman Programs and Citizen Advocacy Organizations, as well as information from SEIU and a September 1999 report by the North Carolina Division of Facility Services. Please send updates, additions, corrections to PHI.

AK – workgroup on staffing; considering wage pass-through and increased training

AL -- does not have any bills at this time but plan to get a work group together in the near future.

AR -- passed legislation last year regarding minimum staffing. For more, see: www.aanhr.org. Wage pass-through also implemented

AZ -- a long term care task force committee has sub-committees on Quality of Care; Regulation and Enforcement; Workforce Development and Retention; Funding, Insurance and Reimbursement. Staffing issues have been discussed in the relevant committees. The sub-committee report is to be presented to the complete task force on November 22, 1999. A wage-pass-through is under consideration.

CA – the budget increased total nursing hours per patient day to 3.2 and eliminated double counting of RN hrs, effective January 1, 2000. It also included a $36 million wage pass-through. The Governor vetoed legislation for additional increases to 3.5 hours by 2003. The Governor also is seeking to delay the January 1, 2000 implementation of the 3.2 hr. requirement.

CO – working on a proposal for a staffing bill but still not sure if it will go ahead. Health dept reports that a voluntary wage pass-through for home care workers has been implemented.

CT – a bill was raised to increase staffing ratios but it didn't go forward. Instead, the Governor agreed to increase Medicaid reimbursement rates by 10% with an infusion of $200 million, to go towards raising salaries and benefits, but not necessarily towards increased staff/resident ratios. The Select Committee on Aging will likely raise the issue again in the 2000 session.

DC -- no new initiatives legislatively. Discussions have occurred within the state licensing department, but nothing concrete has been decided upon.

DE – ratios bill introduced this year but didn't pass. Will be re-introduced next session. Task force looking at workforce availability issues, and whether problems stem from low staffing levels or inadequate training. Legislation passed to double training hours from 75 to 150 hours.

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FL -- the Florida Legislature passed legislation this year giving the nursing homes $40 million to use to increase staffing and CNA wages in nursing homes. A more comprehensive piece of legislation requiring the homes to have specific staffing ratios did not pass out of committee.

Another part of the legislation that the governor did sign requires the Department of Elder Affairs to examine the marketplace for CNAs, including their wage structure.

GA -- advocates in Georgia are developing legislation for introduction for the 2000 General Assembly to: (1) introduce staff/resident ratios (based largely on NCCNHR recommended standards; GA regulations currently require 2.0 nurse staffing hours per resident per day); and (2) develop a study committee to look at staffing issues in LTC broadly (i.e. not only nursing homes, but also home health, assisted living/personal care homes, etc.).

HI – no activity reported.

IA – no legislative action. Last year there was discussion of a wage pass-through but nothing materialized. Iowa funded a study through the Iowa Caregivers' Association that looked at non-wage factors affecting retention of CNA staff. The Association has produced a preliminary report with recommendations.

ID -- no activity reported.

IL -- specific language to increase the ratio was introduced but did not make it out of the committee to be heard by any more than the committee members. Bill pending for 2000 – would establish ratios of 1:5, 1:8, and 1:12 with additional acuity based staffing system. State agency reports a wage pass-through for home care workers.

IN -- advocates are discussing proposals for increased nurse/CNA ratio requirements and increased CNA training requirements. Legislation was introduced last year that, in addition to other reforms, included minimum staffing ratios. The bill was amended and the final version recommended a study of staffing issues by a legislative study commission. The bill made it to joint committee but failed to be brought up for vote in the closing moments of the session.

KS -- legislature passed a voluntary wage pass-through last session (S.B. 126). Signed into law by the Governor, it is "a quality enhancement wage pass-through program as part of the state Medicaid plan to allow nursing facilities electing to participate in such program a payment option of not to exceed $4 per resident day designed to increase salaries or benefits, or both, for those employees providing direct care and support services to residents of nursing facilities."

KY -- no legislation re: staffing issues and none proposed at this time for the 2000 legislative session. Legislature doesn't meet until Jan and then for only 60 days and not again until 2002. Any real work will have to be done through the regulatory process. Grass roots efforts are being targeted there through a very active work group looking at the issues.

LA -- in the '99 legislative session, a bill on ratios was introduced, but never made it out of Committee. There is still potential for passage of legislation for a pass-through for increased reimbursement for staffing. Advocates hope to revive the staffing ratio bill for the 2001 session.

MA – Bills introduced for staffing ratios of 1:5; 1:8; 1:12-15. Coalition of advocates, labor, and providers have formed group to seek passage of ratios and 10% wage pass-through. Dept of Public Health is looking at staffing hours and training as part of its regulatory revision process. A wage pass-through was implemented for home care workers funded through the Elder Affairs.

MD – Bill passed in March establishing a two-year study of staffing in nursing homes. Nursing Home Task Force is underway with workgroups looking at staffing/quality care and residents' rights. Recommendations of the Task Force are due to the Governor December 1. They will be recommending a higher staffing ratio.

ME -- staffing bill was carried over. A state agency reports that a wage pass-through for CNA's was implemented. A Task Force has been underway and has issued a report.

MI – Bill passed House and is pending; would increase direct care hours from 2.25 to 3.0 per resident per day. A state agency reports that a CNA wage pass-through was implemented.

MN -- in the most recent legislative session a bill passed that increases the wages for non-professional direct care staff in nursing homes and home health care. A workgroup on workforce issues is underway.

MO -- no legislation or budget items in 1999. In-home providers got a $1.00 per unit (hour) increase starting in July 1999. Silver Haired Legislature passed the NCCNHR staffing ratio in October as one of their top five priorities. The bill will be discussed in the upcoming legislative session. A workgroup on workforce issues in underway.

MS – through nursing home regulations effective Jan. 2000, increased from 2:33 hours of nursing care per resident per day to new ratios based on 2.67 hours of nursing care per resident per day. Revised Personal Care Homes (PCH) regulations to require one resident attendant per 10 residents for the hours of 7:00 a.m. until 7:00 p.m. and one resident attendant per 20 or fewer residents for the hours of 7:00 p.m. until 7:00 a.m., effective January 2000.

MT – wage pass-through of $0.25/hr for all direct care workers in long term care.

NC – advocacy action underway on staffing levels in nursing homes; got increases in staffing in adult care homes in 1997. Division of Facility Services is studying nurse aide recruitment and retention, looking at wages and staffing levels. Bill passed on minimum staffing and training requirements for medication aides in Assisted Living facilities.

ND -- a Task Force on Long Term Care Planning appointed by Governor was established in 1995 to provide recommendations for improving the delivery of ltc services in the State. One area the Long Term Care Planning Task Force is providing recommendations on relates to "Examining the current Nursing Facility Rate equalization policy to determine if any changes to the current law are appropriate." Industry representatives want increases in Nursing Facility rates to increase staff ratios/hours, wages and training. These issues are being studied and may be submitted for proposed legislation in the next biennium.

NE -- nothing has passed or is pending. A workgroup on workforce issues is underway.

NH -- nothing pending to address the nh staffing shortage. Bill introduced to increase hourly wages for direct care providers for persons with disabilities.

NJ – bill passed through committee – would establish ratios of 1:5; 1:8; 1:12 with additional acuity based staffing.

NM – minimum staffing bill passed House and Senate but vetoed by Governor. Will try again.

NV – no legislative action. A workgroup on workforce issues is underway.

NY -- a bill passed through House committee – would establish ratios of 1:5; 1:8; 1:12 with additional acuity based staffing.

OH -- a bill was introduced to establish staffing ratios of 1:5; 1:10; 1:15 for unlicensed nursing staff; plus public right to staffing information. The state has a workgroup that's developing recommendations to increase the labor pool.

OK -- a couple of years ago there was a wage enhancement for nursing staff - a $1.00/hour increase for nurse aides, which got swept away with the minimum wage increase that followed. An "ad hoc" committee of the LTC Facility Advisory Board is looking at enhancements to NA training, with special emphasis on Alzheimer's/dementia care. Recommendations will then go forward, perhaps on to the State Board of Health for changes. OK has had direct care staffing bills in the Silver Haired Legislature and the "real" legislature for the past several years. Both will hear bills again in their next sessions.

OR – state agency reports a wage pass-through for home care workers has been implemented and that a workgroup on workforce issues is underway.

PA -- as of July 1, 1999, new State licensure regulations set the total number of hours of general nursing care provided in each 24-hour period, when totaled for the entire facility, be a minimum of 2.7 hours of direct resident care for each resident (up from 2.3 for intermediary) however, the nursing staff ratios remained the same (RN's & LPN's). Another bill has been introduced which would increase ratios to 1:5; 1:10; 1:15 with public right to staffing information. A workgroup on workforce issues is underway.

PR – no activity reported.

RI – a wage pass-through for home care workers was implemented. A workgroup on workforce issues is looking at issues related to low staff ratios and quality of care.

SC -- passed a minimum patient to staff ratio bill last year. Ratios are 1:9; 1:13; 1:22. A wage pass-through for home care workers was implemented and a workgroup on workforce issues is underway.

SD – no activity reported.

TN – no activity reported.

TX -- nurse aide staffing ratios bill proposed the past two sessions, (4years). Thus far, no bill has successful passed both houses. Advocates will try again next session and will use NCCNHR's recommended ratios. The legislature did appropriate almost $12 million per year to increase reimbursement rates, with the implied purpose to improve staffing at all levels. Outcome measures and procedures are currently being developed by our Human Services Commission to assure the increases are appropriately used. A state agency reports that a wage pass-through for home care workers has been implemented.

UT -- a subcommittee reviewing staff to patient ratios and will report its recommendations to the Health Facilities Committee.

VA -- there is an effort underway by the Joint Commission on Health Care (a legislative commission created by our General Assembly to examine health care issues in the state) to "review the staffing requirements for nursing home facilities and adult care residences to ensure adequate levels of care and adequate enforcement of these standards." The study is to determine whether staffing standards currently in effect in the state are adequate to protect the health, safety, and welfare of nursing home ad adult care residents. Based on a study of the current regulations, practices, and enforcement the commission is to come up with recommendations for enhanced staffing guidelines. The Commission's legislative recommendations will not be out until December. They are examining both the option of phasing in some sort of ratio as well as the option of creating (through the state's reimbursement system) substantial financial incentives for nursing facilities to reach and maintain targeted staffing levels for direct care staff.

Last year's General Assembly also passed a dollar an hour increase for nursing assistants in nursing facilities, which was effective July 1. A wage pass-through has also been implemented for home care workers.

VT -- nothing specific pending or under consideration this session. During the last session, the legislature enacted a statute authorizing monthly wage supplements to all nursing homes. The state will use the nursing home bed tax to pay for the wage supplement. The state anticipates that the bed tax will generate about $4,000,000 per year. Each facility will receive a pro rata share of the revenues based on the ratio of their reported nursing costs to the total reported nursing costs of all facilities. Facilities can spend the wage supplement on wages, salary or fringe benefits for any nursing homes employees other than owners and administrators. They are not required to spend it on nursing or direct care staff. Facilities have been receiving monthly payments since last July. The payments vary greatly depending on each facility's reported nursing costs.

Facilities are not required to report on how they spend the supplement until September of '00. When the state rebases all the cost categories (It is my understanding that this will occur in 3-4 years) it will determine if facilities have been spending their wage supplement correctly. If a facility's cumulative annual wage expenditure (all employees minus owners and administrators) is less than the cumulative total of its wage supplement payments, then the state will determine that the facility has been overpaid and the state will recoup the overpayment.

WA -- currently looking at the whole LTC system via a Joint Legislative/Executive Long-Term Care Task Force. One sub group is looking at training issues. DSHS has also proposed legislation for training requirements. A wage pass-through for home care workers has been implemented.

WI -- amended our nursing home licensure statute slightly over two years ago. The changes took effect in January of this year and results are starting to come in although no formal analysis has yet been done. The changes were in the form of increased required minimum staffing based on the number of residents of specified acuity in a facility. Total number of staff hours per resident per day were raised from 1.25 to 2.00 hrs for limited nursing care; from 2.25 to 2.50 hrs for skilled care, and up to 3.25 hrs for intensive skilled care. As part of the Governor's "Year of the Long Term Care Worker," a taskforce is examining issues related to recruitment and retention of ALL long term care workers. Wage pass-throughs were enacted for nursing home and home health workers.

WV -- a bill was proposed in the legislature that would have resulted in requiring more Registered Nurses in nursing homes. Another bill would have established staffing ratios of 1:5; 1:8; 1:12 with public disclosure of staffing. The bills didn't pass but will likely be reintroduced in the next session. The entire nursing home staffing issue is now being studied by a legislative subcommittee.

WY – Silver-Haired Legislature is supportive of staffing ratios and may bring proposals forward for 2001 session.

Comparing State Efforts to Address the Recruitment and Retention of

Nurse Aide and Other Paraprofessional Aide Workers

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Background Information

Nurse aides and other paraprofessional aide workers are key players in the delivery of health and long term care services. They provide most of the paid long-term care needed by impaired persons whether at home or in a facility. This workforce tends to some of the most basic needs of patients such as dressing, bathing, toileting, eating, assisting with medications, monitoring blood pressure, changing bandages, housekeeping, etc. Their work is fundamental to quality of care and preserving the dignity of persons who must rely on others to help meet many of the routine daily tasks most of us take for granted.

To illustrate the importance of this workforce, the US Bureau of Labor projects that between 1996 and 2006, these workers will be among the top ten occupations having the **largest** job growth. They are also among the top 10 occupations projected to have the **fastest** job growth.

Recruiting difficulties and turnover rates are reported to be a very serious problem for all major long-term care settings in North Carolina (home care, assisted living, and nursing homes). Our state's low unemployment rate (2.7% in June '99 compared to 4.3% nationally) is a cyclical factor that contributes to current worker shortages. However, there are an array of job factors that are structural in nature that also have a direct and significant bearing on worker shortages such as:

- low wages and few, if any, benefits
- no career path
- physically demanding work
- lack of opportunity for meaningful input into patient care
- inadequate recognition and appreciation
- inadequate exposure to "real life" job demands during training

In 1997 NC's median hourly wage for aide workers was $7.26 per hour ($15,101 annually) or 65% of the state's average annual per capita income of $23,168. The 1997 average annual income for aide workers equates to 183% of the current poverty level for an individual, 136% of poverty for a family of 2, and 109% for a family of 3.

Background Information -- Continued

In 1998 NC spent more than $1.4 billion for services that rely heavily on aide workers including nursing home care; intermediate care for the mentally retarded (ICF-MR); CAP-MR/DD; home health aides; in-home aide services including Medicaid funded Personal Care Services (PCS) and CAP-DA; and PCS for adult care homes (does not include any Medicare funds).

NC will need approximately 21,000 more nurse aides and other aide workers over the next 5-6 years. This is well before 2011 when the first wave of baby boomers begins reaching 65. We can expect continued growth in demand for these workers long after 2030 when the last wave of boomers reaches age 65.

2.7% is the lowest seasonally adjusted unemployment rate the state has seen in 20 years.

Annual turnover rates for aides in nursing homes exceed 100%. For 1999, the industry projects the average hourly wage (wages only-no benefits) for nurse aides to be $8.61.

Annual turnover rates in adult care homes are reported to be over

Listed below are median hourly wages for North Carolina for several major job categories in the state likely to be a competing employment option for aide workers (1997 data). • food service -- $5.95 ($12,376 annually) • sales persons/retail -- $7.20 ($14,976 annually) • hand packers/packagers --$7.36 ($15,308 annually) • information clerks/receptionists -- $8.63 ($17,950 annually) • factory workers (unskilled) --$9.05 ($18,824 annually) **Note:** Attachment # 1 includes a state by state comparison of 1997 hourly and annual wages for aide workers; annual aide wages as a percentage of the state's average annual per capita income; whether or not aide recruitment and retention is a major workforce issue in states; and state unemployment data for May 1999.	*140% annually. Based on cost reports submitted to the Department of Health and Human Services (DHHS), the average hourly wage for aides was $7.13(wages only) in 1998.* *The number of inactive nurse aides on NC's nurse aide registry is greater than the number of active nurse aides (approximately 104,000 inactive and 85,000 active – as of September 21, 1999).*

Purpose

The purpose of this report is to: 1. Determine the extent to which aide recruitment and retention is currently a major workforce issue in other states. **2.** Compare unemployment and wage data for aide workers across states and see how aide wages stack up as a percentage of per capita income. **3.** Compare wage data for aides with workers in several competing employment fields. **4.** Identify any public policy trends among states with regard to state actions to address aide wages and/or benefits for publicly funded services. **5.** Determine to what extent states use uniform reimbursement rates across public funding streams for in-home aide services – and examine how this may impact a state's ability to address wage issues for these workers. **6.** Identify major actions states are taking or considering to address aide recruitment and retention issues, if any.	*This paper focuses primarily on wage and benefit issues associated with the aide workforce.*

Methodology

The Division of Facility Services developed a survey to collect information from all 50 states addressing several public policy issues related to aide wages and benefits and identification of any major actions underway or being considered to address shortages of aide workers. Surveys were sent to both state Medicaid agencies and State Units on Aging. The survey was conducted during May and June of 1999. As necessary, follow-up contacts were made with states to clarify information provided or solicit missing information. Based on self-reported responses provided by states, data for key items was compiled and analyzed. Unemployment data, per capita personal income data and median wage data for selected employment sectors (i.e. aides, retail sales, factory, etc.) was obtained from the US Bureau of Labor Statistics. Other sources of data contained in this report are identified in the "Notes" section on page 12.	*46 states responded to the survey (either Medicaid agency, State Unit on Aging or both). No survey responses were received from the states of California, Wisconsin, Ohio, or Vermont. Non-state agency contacts provided information for California and Wisconsin as to whether or not aide*

recruitment and retention is a major work force issue in the state.

Major Trends Among States

1) Of the 48 states from whom information was obtained, 88% (42) said that aide recruitment and retention is currently a major workforce issue.
   - Both the state with the lowest unemployment rate (Minnesota at 2.1%) and the highest unemployment rate (West Virginia at 6.8%) indicated that aide retention and recruitment is a major concern.
   - 33 (79%) of the 42 states indicating this was a major work force issue have either taken action (30 states) or are considering action (3 states) to address the issue.

   (See Attachment #2 for more detailed information on survey results.)

Many states indicated that low unemployment was a factor in poor recruitment and retention. However, several specifically commented that they now view this issue as a more intractable problem that will persist for an extended period regardless of the state of the economy--due to the aging of the population.

2) With regard to public policy actions to specifically address aide wages and/or benefits, a recent but prevalent trend is the concept of a "pass through" wage increase-- the result of a reimbursement increase to providers of which all or some specified portion of the increase is earmarked exclusively for aide salaries and/or benefits.

Wage and Benefit Pass Throughs

- 16 states have approved/implemented some form of a wage pass through.
- Most states implementing mandatory wage pass throughs have done so only in the last year or two. Some states have been providing reimbursement increases that were intended to go to front line and/or aide wages specifically, but the requirement that the increase go to these workers is a recent occurrence.
- 1 state, Iowa, is considering implementation of a pass through.

The following quote captures the extent to which this workforce issue impacts the nation.

"As a social scientist, I don't use the word "crisis" lightly, but I do think that over the next 10 years we face a true crisis regarding frontline workers in long-term care"

(Karl Pillemer, Director, Applied Gerontology Research Institute –at Cornell University)

States have chosen two methods to implement wage pass throughs

- 10 of the 16 states implement pass throughs based on a set dollar amount for workers per hour or patient day. The pass through amounts ranged from $.50 per hour to $2.14 per hour and $4.93 per patient day.

Dollar Amount Pass Through

Arkansas*	Rhode Island
Colorado	South Carolina
Massachusetts	Texas
Missouri	Virginia
Oregon	Washington

** Arkansas indicated their pass through is pending HCFA approval.*

7 states are known to have established minimum wage rates that are higher than the federal minimum wage. The amount above the federal minimum wage ranges from $.10 to $1.35 p/hour. Oregon has the highest minimum wage rate among these states at $6.50 p/hour.

- 6 of the 16 states established wage pass throughs as a percentage of the increased reimbursement rate. For example, 80% of Minnesota's recent 40% rate increase was earmarked for wages and benefits, while Illinois has a law requiring 73% of all rate increases be used for wages and benefits.

One administrator with a state Unit on Aging stated that while he was pleased that the state legislature had approved a dollar wage pass through for nurse aides, he questioned the end results. He pointed out that without setting up a structured pass through system, perhaps a

Major Trends Among States -- Continued

Percentage Pass Through

California	Michigan
Illinois	Minnesota
Maine	Montana

- Of the states implementing wage pass throughs, 9 targeted only home care aide workers (no facility based care); 4 targeted only direct service workers in nursing facilities, and 3 targeted both home care and nursing facilities. At least one state which provided a wage pass through only to its home care workers stated that it was likely that their nursing facility workers would receive a wage pass through in the near future.

Home care only:	*Nursing facilities only:*	*Both/all LTC:*
Colorado	Arkansas	Minnesota
Illinois	Maine	Montana
Massachusetts	Michigan	Virginia
Missouri	California	
Oregon		
Rhode Island		
South Carolina		
Texas		
Washington		

- It is interesting to note that of the 9 states providing increases to only home care aides over half had uniform reimbursement rates across multiple funding streams. Of the 16 states implementing wage pass throughs, that provided information on the pass throughs funding source(s), 6 appear to use multiple funding streams (Medicaid plus additional sources). Of the remaining 10 states, 6 appear to use only Medicaid or only non-Medicaid funding sources, and 4 did not provide this information.

- The majority of states who have a wage pass through in place stated that monitoring providers' compliance with the wage and benefits requirement has not been, or is not expected to be, an undue burden for their agencies. Some states have required/will require providers to submit an initial plan describing usage of the additional funds, and then confirm compliance when the state audits providers. Other states provide additional funding to providers without an initial plan but ensure compliance by reviewing fund usage during annual audits. For some states, implementing a wage pass through system is still very new and they have not yet determined the most effective, low-cost way to monitor providers and ensure compliance.

percentage of any annual increase in reimbursement rates, the problem had not been permanently solved. In a few years wages in other low level jobs will catch up to aide wages, and the state would once again face the same recruitment and retention problem.

The majority of wage pass throughs in place in states are intended to be distributed equally to all nurse aides. However, some states allow the long term care facilities/agencies to determine which front line staff receive the additional funding and what percentage is used for wages versus benefits.

Sanctions against providers who failed to use the funds for wages or benefits usually consist of immediate repayment by the provider of the inappropriately used monies. In Missouri, however, the state has linked failure to comply with the wage increase and reporting requirements to the possible revocation of the provider's Medicaid status.

Major Trends Among States -- Continued

3) **Enhancement Incentives**

Another trend closely related to the concept of a wage pass through is the effort by states to tie increased reimbursement rates to increased performance by providers and staff. Rhode Island recently authorized a $1.50 hourly rate increase to be used for direct service staff wages, but in addition to these monies, the state also authorized additional monies to be used as an incentive to enhance standards. As of September 1999, the

state will offer additional hourly reimbursement in seven primary areas: shift differentials, client satisfaction, level of patient acuity, level of provider accreditation, continuity of care, and level of worker satisfaction. Rhode Island currently has an enhancement system in place with bonuses ranging from $.50 per hour to $2.00 per hour but this new system is more intricate with the possibility of up to $6.00 per hour in additional reimbursement above the base rate.

4) Higher State Reimbursement Rates for Shift Differentials

Like Rhode Island, New Jersey has focused on the idea of establishing higher reimbursement rates for in-home aide services provided at night, weekends and holidays. States focusing on shift differentials think that the increased reimbursement rates for certain time periods will help provider's recruit and retain aide staff.

5) Transportation Reimbursement

One state, Washington, also indicated that they recently passed legislation requiring home care providers to pay their aides for "windshield time." Windshield time is the time spent by the staff traveling from one site to another. At this time, the additional funding for the travel time is paid from the state reimbursement rate for personal care services. Florida's Department of Elder Affairs Work Group has also recommended that the state review transportation reimbursements for aide staff.

Rhode Island is still working to find an effective means of operationalizing these additional incentives. While the state, providers and associations all see the measures as a step in the right direction, state staff stated that it has been difficult to get all parties to agree on the measures and systems to be used.

6) Nurse Aide Career Ladders

Several states noted that they had considered creating some form of a career ladder for aide staff. Mississippi has established two separate sets of standards, one applying to homemaker and another to personal care aides, as a basic career ladder. Maine and Alaska are both considering ways to create some form of a career ladder, while Illinois has a bill pending which would authorize the creation of a resident attendant category of worker for nursing homes. These workers will undergo training to provide basic support services to fully trained nurse aides. Delaware's State Legislative and Citizens Investigative Panel on Nursing Home Reform has also recommended the development of a career ladder including at least three levels; intern, team member, and team-preceptor. Each level would result in an increased pay level.

Major Trends Among States – Continued

7) Nurse Aide Training

In addition to the creation of a career ladder for nurse aides, states are focusing on the training provided to this population. By providing or proposing different levels of training, states like Mississippi, Delaware and Maine hope to provide nurse aides with an incentive to continue in the profession. Virginia also recently increased the minimum training hours for nurse aide programs from 80 to 120 hours.

Home care aides in New Jersey are paid $14/hour for weekday services, while aides working weekend hours are paid $16/hour. In NC, many individual providers (home care agencies and facilities) pay shift differentials. However, this initiative is different in that the <u>state</u> reimbursement rates are stratified based on the time that <u>home care</u> services are provided.

8) Training Former Welfare Recipients

Multiple states indicated that their welfare reform efforts have been seen as a potential source for nurse aide trainees. Workgroups in New Mexico and Florida have recommended funneling welfare recipients into nurse aide training programs, while New Jersey's welfare reform training has resulted in some new home health aides.

9) Training of Volunteer Populations

Along with the idea of tapping into new populations to increase the number of nurse aides, including former welfare recipients, is the trend to expand the use of volunteers. State workgroups looking at the issue of recruitment and retention have suggested expanding the use of Americorps volunteers, local and state volunteer programs, student volunteers, and senior citizens. The Maine Health Care Association Long Term Care Task Force has also advocated modifying aspects of the nurse aide job in order to encourage seniors to become a part of this workforce.

States indicating they were considering or taking action on the creation of a career ladder for nurse aides include Mississippi, Maine, Alaska, Illinois, Delaware, and Michigan.

10) Pilot Programs

Three states discussed the implementation of pilot incentive programs to encourage aide recruitment and retention. Wisconsin, Iowa and Oklahoma each have either funded or proposed pilot programs that focus on enhancing the quality of life for direct care workers and reducing staff turnover.

11) Overall Labor Shortage Area

At least one state, Florida, said it is looking at the nurse aide issue as part of an overall labor shortage in low-wage jobs. While Florida was the only state to note that they were looking at the issue from this standpoint, several states did note that due to low levels of unemployment, they were faced with a far tighter labor market than they have previously encountered.

Major Trends Among States -- Continued

North Carolina currently requires a minimum of 75 hours of training and a competency test, or only the competency test in order to be certified to work as a Nurse Aide 1.

12) Work Groups / Task Forces / Data Collection

Though many states have not yet implemented specific programs focusing on nurse aide recruitment and retention issues, Work Groups or Task Forces have been or will be established in the next fiscal year by 31% (13) of the states that felt that this was an issue of concern. Participants in the Work Groups represented people from a wide range of groups, including representatives of the state Boards of Nursing, provider groups, state Departments of Health and Human Services and Aging, patient advocates, and certified nursing assistants. For the most part, these groups are charged with obtaining data and analyzing the situation, and then providing both short and long-term recommendations. The legislatures of an additional two states, Iowa and Virginia, have requested the appropriate state agencies to collect data on the issue of nurse aide recruitment and retention in order to determine appropriate next steps.

States indicating they were making a concerted effort to broaden the pool of potential aide workers by looking at former welfare recipients as potential nurse aides include New Jersey, New Mexico, Florida and Arkansas.

	The NC Division of Facility Services has received funding from the Kate B. Reynolds Charitable Trust to pilot an array of incentives intended to improve aide recruitment and retention in long-term care settings.
	States that have established or plan to establish a Work Group or Task Force include: *Alaska* *Arizona* *Rhode Island* *Maryland* *Delaware* *Minnesota* *Florida* *Nebraska* *Maine* *Nevada* *Oklahoma* *Pennsylvania* *Missouri* *The Legislatures of Iowa and Virginia have mandated data collection efforts by state agencies.*

Conclusion

Nurse aide and paraprofessional worker shortages are a serious problem for North Carolina and the nation as a whole. Although low unemployment rates both in the state and nation increase competition for all workers, shortages and turnover rates among the aide workforce cannot be attributed solely to the state of our booming economy. Structural job factors contribute heavily to the	*Ensuring an adequate and stable supply of nurse aide and other paraprofessional workers is essential to*

problem and, in the absence of examining and alleviating these structural job factors, other employment opportunities of similar or even better pay or benefits and perhaps less demanding work will drain an already shrinking pool of potential aide workers.

Many states are taking action to address this workforce issue. They recognize that demand for these workers will only increase as the population ages. Certainly North Carolina's health and long-term care providers have a major responsibility to help address this workforce issue. However, given the level of the state's financial investment in services that heavily rely on the aide workforce, the state too shares in the responsibility for addressing this workforce issue. Confirmation of the public sector's responsibility is evident from the growing number of states that are taking action or considering actions to alleviate worker shortages and turnover. Collaboration with various trade associations representing various health and long-term care providers will be key to success both now and over the long haul.

The Department of Health and Human Services is already taking steps to tackle this workforce issue. While current efforts can lead to major steps in the right direction, additional action is needed now. Outlined below are a number of actions North Carolina could consider in addition to those efforts already underway with funding from the Kate B. Reynolds Charitable Trust. The potential of each of these possible actions will need to be fully assessed. They are provided as a starting point for further discussion and analysis.

meeting future health and long-term care demands. This issue effects both public and privately funded health and long-term care. Many family and informal caregivers rely on this workforce so they can continue to work and support their families.

Because this paper focuses primarily on wages and benefits, so, too, do the possible actions considered in this paper. Obviously, there are other areas that could be examined such as possible actions to broaden the workforce.

Some Actions North Carolina Could Consider

The actions below focus primarily on wage and benefit issues. The Division of Facility Services is currently working on several grant funded initiatives intended to address other job factors that impact the recruitment and retention of a stable and qualified aide workforce. The actions below are in addition to efforts already underway through a grant from the Kate B. Reynolds Charitable Trust.

1) The Department of Health and Human Services (DHHS) could help facilitate a discussion among representatives of major state level associations that rely on aide workers to determine interest in, and the feasibility of, leveraging their collective purchasing power (and broaden the risk pool) for purposes of offering one or more group health insurance plan(s) to member providers that do not currently offer health insurance coverage to their employees or provider members who could benefit from either improved coverage or pricing as a result of such an effort. This could potentially improve access to health care insurance coverage for all employees of provider member organizations.

2) The Division of Facility Services could include, with letters sent to newly listed certified nurse aides, general information about NC's Health Choice for Children insurance program. Last year, the Division sent letters verifying listing on the nurse aide registry to approximately 15,000 persons. This would enhance efforts taken by state level trade associations to inform member organizations about the availability of this program. Similar action could be taken by other DHHS agencies that send correspondence to provider organizations as a way of reminding providers to notify their employees of the availability of this program.

3) Medicaid reimbursed providers have an avenue to increase wages for workers in that calculations for inflationary increases awarded by the

Key activities underway through funding from the Kate B. Reynolds Charitable Trust include:

- *developing an automated data tracking system to track this workforce over time.*
- *provide nurse aide I trainees with more hands-on-care time so they get a more realistic view of what this type of work entails.*
- *pilot a variety of employee incentives intended to improve job skills, job satisfaction and performance thus resulting in improved recruitment and retention. (The results of these incentives will not be known until late 2001.)*
- *conduct a public education and awareness campaign about the importance of this workforce.*

The Division of Facility Services is working with the Institute on Aging, representatives of state level long-term care related trade associations and others to implement the grant activities above.

If inflationary increases do not reflect the actual annual inflation rate (i.e. increases are awarded less than annually and/or in amounts

Division of Medical Assistance assume that 75% of increases for PCS services (in-home and adult care home) and 80% of the direct care portion of inflationary increases for nursing homes are to support increases in direct labor costs. Do providers use the same proportion of inflationary increases for direct labor costs as the calculation assumes? Examination is needed to determine whether those providers that pay higher wages also have retention rates that are better than those that pay the average or lower wages.

less than the overall inflationary rate for the year) the direct labor component of the calculation is eroded (as are the remaining components of the inflationary increase) -- even if the provider uses the entire 75% -80% allocated for direct labor costs.

4) Consider a wage pass through (an amount or percentage increase in the reimbursement rate in addition to any planned inflationary increase) for Medicaid funded Personal Care Services (PCS: in-home and adult care homes) as well as for nursing home care. The wage pass through amount would be built into the reimbursement rate.

As part of the Kate B. Reynolds Grant, a survey of major provider types (home care, adult care homes, nursing homes) will be done to determine, among other things, whether facilities that pay higher wages also have better retention rates. Generally, this type of information is not now available from major state level long-term care related associations.

Some Actions North Carolina Could Consider -- Continued

- Recognizing that the state's unemployment rate is **1** factor in the availability of a stable and quality aide workforce, inclusion of the wage pass through in the base reimbursement rate in subsequent years could be pegged to the state's overall unemployment rate so that when unemployment rates climb (to some predetermined level) and competition for workers across various competing employer types presumably would decline somewhat, the reimbursement rate could be correspondingly adjusted downward to account for likely reductions in wage pressures for new hires.
- The fiscal impact of a wage pass through (by care setting) and associated compliance monitoring costs by the Division of Medical Assistance, if any, would be needed.
- Action to implement a similar wage pass through for non-Medicaid funded in-home aide services (e.g. Social Services Block Grant or Home and Community Care Block Grant) is impeded by the fact that there are not uniform reimbursement rates across multiple funding streams for in-home aide services. As such, the impact of a wage pass through for providers who have considerable latitude in setting their own reimbursement rates is questionable (regardless of whether reimbursement rates are calculated in a competitive or non-competitive environment). Monitoring efforts to verify compliance with any wage pass through would likely be complicated by the fact that reimbursement rates vary so widely across providers.

Things North Carolina needs to consider with regard to consideration of a wage pass through:

- *this is a relatively new concept*
- *NC doesn't currently have substantial reliable data available to confirm that higher aide wages translate into improved aide recruitment and retention. (This is, however, one component of the data collection activities being undertaken through the aide recruitment and retention grant made to DHHS by the Kate B. Reynolds Charitable Trust.)*
- *Compliance monitoring efforts by states vary. Given the short history of wage pass throughs, it is likely that states will need additional time to determine overall compliance with wage pass through requirements as well as the administrative and cost efficiency of compliance monitoring efforts.*

While it may appear that the following items do not directly relate to improving aide recruitment and retention, they do relate to service access and making the most efficient use of public resources available for in-home aide services. Government is a major payor and by established rates can have a significant influence on wages and benefits paid to the long-term care workforce. Outlined below are several issues that need further study to ensure that the public policy goal of strengthening the long-term care workforce is met through public payors.

The current Medicaid reimbursement rate for Personal Care Services is $12.32 per hour.

1) Consider establishing a uniform reimbursement rate(s) across state administered funding sources for in-home aide type services. This is consistent with other Department of Health and Human Services efforts to establish uniform reimbursement rates for like services funded by multiple agencies or with multiple public funding sources.

SFY 2000 <u>average</u> hourly <u>reimbursement</u> rates for the two levels of in-home aide services that include personal care for agencies providing

- The Department of Health and Human services recognizes 4 different levels of in-home aide services – Medicaid (in-home) Personal Care Services (PCS) pays for 2 of these levels -- the levels that include personal care tasks.
- Having multiple rates that are tied to the different levels of in-home aide services is one way the department could help to establish a career ladder for workers in the home care setting.
- Development of Medicaid PCS rates is based on cost information submitted by providers. If a uniform rate(s) across state

Some Actions North Carolina Could Consider – Continued

administered public funding streams were pursued, there may be a need to have uniform cost information submitted by providers across these public funding streams. Cost data submitted would need to be reviewed for accuracy and reasonableness for purposes of establishing a reasonable uniform rate(s) that would be paid across public funding streams for provision of in-home aide services.

2) Consider requiring that all <u>licensed home care agencies</u> that receive state administered funds for in-home aide services or in-home respite services (i.e. SSBG, Home and Community Care Block Grant (HCCBG), etc.) be enrolled to provide Medicaid PCS services <u>and serve</u> some Medicaid PCS clients each year. The Division of Aging would need to monitor providers for compliance with such a requirement.
   - For SFY 99, of the 112 agencies funded to provide level II and III in-home aide services through the Home and Community Care Block Grant (levels that include personal care), 60 of the 112 were either not currently enrolled to provide Medicaid funded PCS or were enrolled but did not bill Medicaid for any PCS services between January and May of 1999.
   - Of the 60 providers that did not bill Medicaid for any PCS services between January and May 1999:
     ⇒ Half (30) had reimbursement rates equal to or less than the current PCS reimbursement rate of $12.32.
     ⇒ Half (30) had reimbursement rates higher than $12.32 and of these:
       - 16 (53%) had reimbursement rates of $18 per hour or more
       - 5 (17%) had reimbursement rates within 60 cents of $12.32
   - The adequacy of the reimbursement rate for Medicaid PCS needs to be assessed prior to implementing such a requirement as some providers have expressed concern about their inability to provide the service for the amount of reimbursement paid by Medicaid. This is directly related to aide wages/benefits as some of these providers indicate they pay aides better from other funding sources that are not tied to the Medicaid rate for PCS. For instance, calls made to several HCCBG providers with rates higher than the Medicaid PCS rate who were not enrolled in Medicaid as a PCS provider showed that generally, these agencies were providing benefits such as retirement and health insurance (at least partial pay) as well as other group insurance offerings on an employee pay all basis. Some of these same agencies also indicated that they had a fairly stable aide workforce. Further examination is needed to determine whether agencies paying higher than average wages for both new hires and/experienced aides and whether or not there is any correlation between higher wages and turnover. Further examination is needed to determine why HCCBG providers with rates at/below the Medicaid PCS rate are either not enrolled as a PCS provider or not billing Medicaid for PCS services.

these services through the Home and Community Care Block Grant are as follows:

Level II -- $13.04 (includes personal care tasks that do not require a nurse aide)

Level III --$13.39 (includes personal care tasks that require a nurse aide)

Note: <u>reimbursement</u> rates may or may not reflect total cost.

Requiring HCCBG providers to provide PCS services could possibly help alleviate an unexpected situation that occurred in 42 counties during SFY 97-98 where more elderly (60+) CAP-DA clients were served than elderly persons receiving PCS services. In-home aide is the predominant service provided to CAP-DA clients. As such, given the high level of impairment required for participation in CAP-DA (participants must need nursing home level care) and the average annual cost of waiver services per CAP-DA participant ($13,561 in 97-98), one would certainly expect there to be more elderly persons in need of

Some Actions North Carolina Could Consider -- Continued

This step could have multiple benefits including:

- expanding the state's capacity to meet the PCS needs of Medicaid eligible persons-- particularly the elderly since persons 65+ accounted for 71% of total PCS spending in SFY 97-98.
- increasing the number of active PCS providers would be especially beneficial in areas of the state where Medicaid clients currently have limited access to PCS services due to a limited number of providers.
  - For instance, in SFY 97-98 **16** counties had total PCS expenditures for the elderly of $50,000 or less. Based on an average per person cost of $4,387 for persons 60+ in SFY 97-98, $50,000 in PCS expenditures would equate to 11 persons served during the year.
- increased numbers of PCS providers could help address waiting lists for the Community Alternatives Program for Disabled Adults (CAP-DA) – either as a gap filling service until a CAP-DA space is available or perhaps in some cases, provide an adequate and less costly alternative to CAP-DA -- since the overwhelming majority of CAP-DA expenditures are for aide services.
- improving continuity of care and consumer satisfaction by avoiding having to shift clients from one agency to another based on the public funding source used to provide care.
- reducing the chances of inappropriately using non-Medicaid funds (which are capped) to meet the personal care service needs of Medicaid eligible clients.

3) In lieu of establishing uniform rates for in-home aide services, consider limiting the amount of indirect costs that can be included in the calculation of reimbursement rates for non-Medicaid funded in-home aide services. In fact, such a requirement may be appropriate for all services provided under these auspices.

- this would also help ensure that a minimum percentage of the provider's reimbursement rate is used for direct care costs.
- this would also help to eliminate the possibility of some providers being paid reimbursement rates that exceed what an informed consumer would be willing to pay for services on the private market.
  - ⇒ Shown below are the number and percentage of HCCBG in-home aide provider contracts (by level) for SFY 2000 with reimbursement rates of $18 p/hour or higher. It is interesting to note that level I, the level requiring the lowest skill level (contains no personal care tasks), has the highest percentage of contracts exceeding $18 p/hour.

	Total Contracts	Contracts Over $18 p/hr.	Percent
Level I	88	14	16%
Level II	111	14	13 %
Level III	56	8	14%

(and receiving) Personal Care Services in a county than persons participating in the highly targeted CAP-DA program. (CAP-DA provides a package of home and community based services for Medicaid eligible persons 18+ who otherwise need nursing home care.)

Requiring HCCBG providers to be enrolled as PCS providers in and of itself would not necessarily result in agencies serving more in-home aide clients (including Medicaid PCS). The potential impact of this action would hinge, in part, on the ability of agencies to hire and retain enough qualified aides to operate aide services at full capacity. However,

given that the Medicaid PCS rate is fairly consistent with the average reimbursement rate for agencies providing in-home aide services through the Home and Community Care Block Grant ($12.92) many providers could conceivably benefit positively from accessing this revenue stream.

	*As mentioned earlier, the **average** reimbursement rate for Home and Community Care Block Grant providers for SFY 2000 is $12.92 per hour. There is, however, a wide variation in reimbursement rates across providers with contract reimbursement rates for SFY 2000 ranging from a low of $6.62 per hour to a high of $37.11 per hour.* *Calls randomly made to 7 home care agencies in a large urban area to determine private pay rates for nurse aide services showed that rates charged by these 7 agencies ranged from $13 to $16 per hour. Fifteen dollars was the most prevalent rate with 4 of the 7 charging this rate. Some agencies noted that they required a minimum visit time of 2 hours. One agency charged a shift differential of $1.00 per hour for night and weekend work increasing their private pay rate to $16 for night and weekend work.*

Acknowledgements

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Notes

- Expenditures for aide related services were compiled based on expenditures reported by the Division of Medical Assistance in their annual report for SFY 97-98 including Personal Care Services (in-home and adult care homes) and nursing home care, ICF-MR, CAP-MR/DD and CAP-DA. CAP-DA calculated at 90% of Medicaid CAP-DA expenditures reported for SFY 97-98 which is consistent with the percentage of aide service costs for waiver year 96-97. Aide related expenditures also include in-home aide service expenditures reported by the Divisions of Aging and Social Services.
- Projected 1999 wages for nurse aides working in nursing homes were obtained from the NC Health Care Facilities Association.
- 1998 average aide wages for aides in adult care homes were calculated by Financial Operations staff in the Division of Medical Assistance. Calculations were based on data contained in audited cost reports for 1998 submitted to the Department of Health and Human Services from adult care homes.

- Information about whether aide recruitment and retention is a workforce issue in the state of California was obtained from staff with the Center for Health Professions – University of California at San Francisco.
- Information about whether aide recruitment and retention is a workforce issue in Wisconsin based on efforts by Wisconsin's Alzheimer's Institute and University of Wisconsin-Madison Medical School to obtain grant funding to address aide recruitment and retention in the state.
- Data regarding providers both billing Medicaid for PCS and providing Home and Community Care Block Grant providers was determined by cross referencing active PCS providers from Medicaid's "DRIVE" system with SFY 98-99 Home and Community Care Providers funded for level II and III in-home aide services through the Division of Aging. The report on Medicaid PCS providers was created by staff in the Division of Facility Services using NC Medicaid data.) *Note*: *The Division of Medical Assistance has not reviewed the active provider report and, therefore, cannot validate the accuracy of the information contained in the report.*
- Average reimbursement rates and the range of contracted rates, by in-home aide level, for Home and Community Care Block Grant providers were calculated based on contract information for SFY 2000 (ZGA515 – run date: 8/31/99) – average rates are not inclusive of any cost-sharing revenues collected.
- Data regarding counties serving more Medicaid CAP-DA clients than PCS clients is based on county-by-county expenditure data for SFY 997-98 for persons 60+ as compiled by the Division of Aging.
- State by state unemployment and compensation data for 1997 was obtained from the US Bureau of Labor Statistics.
- Ratio's of PCS expenditures (elderly vs. non-elderly) based on expenditure data reported in the Division of Medical Assistance's annual report for SFY 97-98
- The average annual PCS expenditure for persons 60+ is based on expenditure and service data (persons served) provided by the Division of Medical Assistance to the Division of Aging for SFY 97-98.
- Average annual per participant expenditures for CAP-DA for 97-98 based on data reported in the Division of Medical Assistance's annual report on CAP-DA for waiver year 97-98 (published April 30, 1999).

New York
Standard

Staffing ratio = number of personnel on duty) number of residents of the nursing home.

Nursing homes are required to maintain the following ratios:

Registered Nurses: 1:15 Day Shift
1: 25 Evening shift
1: 35 Night Shift

Licensed Care Givers: 1: 10 Day Shift
1:15 Evening Shift
1:20 Night Shift

CNAs: 1:5 Day Shift
1:8 Evening Shift
1:12 Night Shift

Professionl Nurse Coverage
A nursing home shall maintain
- A full-time DON who is also a RN
- A full-time nursing supervisor who is also a RN
- A full-time Director of Nurse and nurse aide education who is alos a RN

If there are greater than 100 beds,
- A full-time assistant director of nurses who is a RN
- A full-time director of in-service education

Staff Counted in Standard
Individuals employed to provideservices such as food preparations, housekeepingk, laundry or maintenence shall not be counted in determining the above staffing ratios.

Ohio
Standard

Nursing homes are required to maintain the following rations:

Registered Nurses: 1:15 Day Shift
1: 25 Evening shift
1: 35 Night Shift

Nurse Aides: 1:5 Day Shift
1:10 Evening Shift
1:15 Night Shift

Professionl Nurse Coverage

A nursing home shall maintain

- A full-time DON who is also a RN
- A full-time nursing supervisor who is also a RN
- A full-time Director of Nurse and nurse aide education who is alos a RN
- If there are less than 100 beds, one RN can fulfill the duties of assistant director of nurses and director of nurse and nurse-aide education.
- A RN 24 hours per day, 7 days per week

Staff Counted in Standard

Individuals employed or contracted to provide services such as food preparations, housekeeping, laundry or maintenance shall not be counted in determining the abouve staffing rations.

Posting

The nursing home administrator shall post, in a prominent location withing the nursing home,

- the number of nurses and nurse aides scheduled to work,
- the number of nurses and nurse aides who performed work,
- the number of residents at the facility, and
- the staffing rations.

Continued Studies

A legislative committee will study the adequacy of staffing ratios

Texas

Standard

Nursing homes are required to maintain the following rations:

Nurse Aide:	1:8 Morning Shift
	1:10 Afternoon Shift
	1:14 Night Shift